04686

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Worcester — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ocean City — LENGTH OF STAY (in this place) 47 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Worcester.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ocean City.
STREET ADDRESS (If rural, give location) 1st & Baltimore Ave.

3. NAME OF DECEASED (Type or Print): (First) Harriet (Middle) Hickman (Last) Crofper.
4. DATE OF DEATH: (Month) April (Day) 30 (Year) 1952

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: June 6, 1885
9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Accomac Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac R. Hickman
14. MOTHER'S MAIDEN NAME: Mary S. Applebutter.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): No.
16. SOCIAL SECURITY No.: No
17. INFORMANT AND ADDRESS: Mr. Harry Crofper Ocean City Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 24 hours

331.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1947, to 30 Apr, 1952, that I last saw the deceased alive on 30 Apr, 1952, and that death occurred at 10:30 P m., from the causes and on the date stated above.

SIGNATURE: H. R. Showers — (Degree or title) M.D. — ADDRESS Ocean City, Md — DATE SIGNED 1 May 52

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 5/2/52 — NAME OF CEMETERY OR CREMATORY Evergreen — LOCATION (City, town, or county) Berlin — (State) Md

DATE REC'D BY LOCAL REG. 5-2-52 — REGISTRAR'S SIGNATURE Helen F Hayward

24. FUNERAL DIRECTOR — ADDRESS Homer A. Burbage Berlin Md.

RECEIVED
MAY 6 1952
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 04687

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Worcester — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin — LENGTH OF STAY (in this place) 9 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
STREET ADDRESS (If rural, give location) Ocean City Blvd.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Spencer	D	Davies	April	18	1952

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Aug. 31, 1885	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ins. Man. Life Ins.	Ins. Life Ins.	Cadiz Pa	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Stanley S. Davies	Sarah Davies

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	188-10-7617	Mrs. Spencer Davies Berlin Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	2 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 420.0	(b) Cardiac Glomerulo nephritis	6 months
	(c) Arteriosclerotic Heart disease	2 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 26, 1951, to April 18, 1952, that I last saw the deceased alive on April 17, 1952, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
T. J. O'Donnell	M.D.	Berlin, Md	4/19/52

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	4/24/52	Homewood (?)	Pittsburg	Pa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-21-52	Helen F Hayward	Anna A. Burbage	Berlin Md

RECEIVED
APR 23 1952
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04688

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH COUNTY: Worcester MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Newark — LENGTH OF STAY (in this place): All life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Newark
HOSPITAL OR INSTITUTION OR STREET ADDRESS: At home	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Mahala Foreman			4. DATE OF DEATH (Month) (Day) (Year): 4 - 23 - 1952		
5. SEX: Female	6. COLOR OR RACE: A. A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: About 1862	9. AGE last birthday: About 90 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: At home		11. BIRTHPLACE (State or foreign country): Newark, Worcester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Johnson			14. MOTHER'S MAIDEN NAME: Amilla Quinton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No	16. SOCIAL SECURITY NO.: None		17. INFORMANT AND ADDRESS: Miss Joanna Foreman, Newark, Maryland		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 X

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-, 1941, to 4-23, 1952, that I last saw the deceased alive on 4-20, 1952, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE: Clifford E. Schott M.D. (Degree or title) ADDRESS: Berlin Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 4-27-52	NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery	LOCATION (City, town, or county) (State): Newark, Worcester Co. Md.
DATE REC'D BY LOCAL REG.: 4/26/52	REGISTRAR'S SIGNATURE: LeRoy Smith	24. FUNERAL DIRECTOR: James B. Dashiell, Easton, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 2 1952
BUREAU V. S.

Item 9 Film G140 4/14/52 whw

MARYLAND STATE DEPARTMENT OF HEALTH 04689

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Worcester; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bishopville; LENGTH OF STAY (in this place) 40 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bishopville; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) J. (Last) Fookey

4. DATE OF DEATH: (Month) Apr. (Day) 2 (Year) 1952

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 12/31/82

9. AGE last birthday: 69 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming – farm owner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Delmar Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nathan Fookey

14. MOTHER'S MAIDEN NAME: Henrietta Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If year, give war or dates of service): —

16. SOCIAL SECURITY No.: —

17. INFORMANT AND ADDRESS: Annie Fookey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Interval Between Onset and Death: 3 days

610X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prostatism — 10 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple Sclerosis — 10 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950 to April 2, 1952 that I last saw the deceased alive on April 2, 1952, and that death occurred at 1 20 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William N Young M.D. Selbyville, Del. April 3, 1952

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Apr. 4, 1952

NAME OF CEMETERY OR CREMATORY: Odd Fellows Cem.

LOCATION (City, town, or county) (State): Bishopville, Md.

DATE REC'D BY LOCAL REG. 4-4-52

REGISTRAR'S SIGNATURE: Roy Bergey

24. FUNERAL DIRECTOR ADDRESS: Henry L. Watson, Pocomoke City, Md.

CM

RECEIVED
APR 7 1952
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
LENGTH OF STAY (in this place) 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) Godfrey

4. DATE OF DEATH: (Month) April (Day) 24 (Year) 1952

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 19-1889
9. AGE last birthday: 63/0/5 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch maker
10b. KIND OF BUSINESS OR INDUSTRY: Own Shop
11. BIRTHPLACE (State or foreign country) Snow Hill Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Francis Godfrey
14. MOTHER'S MAIDEN NAME: Jennie Marvel

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Mrs Lillie M Godfrey, Snow Hill, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

331X

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Hypertension — 2 yrs

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death: Bronchiectasis and asthma — 10 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1944, to April 24 1952, that I last saw the deceased alive on April 24, 1952 and that death occurred at 6:30 p.m., from the causes and on the date stated above.

SIGNATURE: Beulah LaMar (DEGREE OR TITLE) MD ADDRESS Snow Hill Md. DATE SIGNED 4.26.52

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: April 28/52
NAME OF CEMETERY OR CREMATORY: Whatcoat
LOCATION (City, town, or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REG. 4/26/52
REGISTRAR'S SIGNATURE: LeRoy Smith
24. FUNERAL DIRECTOR: Mary E Dennis ADDRESS Snow Hill Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH 91

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 332 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. ALA

1. PLACE OF DEATH: COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin; MARYLAND; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital, give street address or location) Berlin to Pg Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Willie (Middle) Samuel (Last) Graham

4. DATE OF DEATH: (Month) April (Day) 24 (Year) 19[illegible]

5. SEX: M

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE: Last Birthday [illegible] yrs.; If under 1 year: Months; Days; If under 24 hrs: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Nursery

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Homicide by knife (with hemorrhage) Result of Stab wound of liver

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible] (c)

Interval Between Onset and Death: Hours

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Farm Packing House (CITY OR TOWN) Berlin (COUNTY) Worcester (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) April 24 1952 12:20 a.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Left Knife cut liver

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the date stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐

SIGNATURE: [illegible] (Degree or title) ADDRESS: Dr. McEvers Snow Hill Md DATE SIGNED: 4/24/52

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: 4/29/52 NAME OF CEMETERY OR CREMATORY: St. Paul's LOCATION (City, town, or county): Berlin (State): Md

DATE REC'D BY LOCAL REG. 4-29-52 REGISTRAR'S SIGNATURE: Mary M Holloway Helen F. Hayward-com

24. FUNERAL DIRECTOR: [illegible] ADDRESS: [illegible]

RECEIVED
MAY 1 1952
BUREAU V. S.

192

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Worcester — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
LENGTH OF STAY (in this place) 88 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
STREET ADDRESS (If rural, give location) Main St.

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Louise (Last) Diamond

4. DATE OF DEATH: (Month) April (Day) 28 (Year) 1952

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow | 8. DATE OF BIRTH: May 1, 1864 | 9. AGE last birthday: 88 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Berlin Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Levin Talbert
14. MOTHER'S MAIDEN NAME: Laura Powell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: n.k.
17. INFORMANT AND ADDRESS: Mrs. Ruth Young Bird

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral apoplexy

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 10, 1952, to April 25, 1952, that I last saw the deceased alive on April 23, 1952, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
Clifford E. Schatt M.D. Berlin Md.

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)
Burial | 4/26/1952 | Berlin Cemetery | Berlin Md

DATE REC'D BY LOCAL REG. 4-26-52 | REGISTRAR'S SIGNATURE: Helen F Hayward | 24. FUNERAL DIRECTOR | ADDRESS

RECEIVED
1952
BUREAU

1693

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 350

1. PLACE OF DEATH COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke City
LENGTH OF STAY his [illegible] Since 1943
HOSPITAL OR INSTITUTION OR STREET ADDRESS 423 Bank St

2. USUAL RESIDENCE (HOME) OF DECEASED STATE Alabama COUNTY 131
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wodowen
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Otis Langston (Last)
4. DATE OF DEATH (Month) April (Day) 19 (Year) 1952
5. SEX M
6. COLOR OR RACE C
7. SINGLE, WIDOWED, DIVORCED (Specify) D.K.
8. DATE OF BIRTH Feb 6th 1920
9. AGE last birthday 32 yrs. If under 1 year Months Days If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yd Bearer
10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill
11. BIRTHPLACE (State or foreign country) Roanoke Alabama
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Langston
14. MOTHER'S MAIDEN NAME Ida Hearn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 424-14-5670
17. INFORMANT AND ADDRESS Ernest Rayfield Pocomoke City Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Hemorrhage. Few minutes

982 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Homicide by Knife

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Drinking (Alcoholics)

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (CITY OR TOWN) Pocomoke City (COUNTY) Worcester (STATE) Md
TIME OF INJURY (Month) 4 (Day) 19 (Year) 52 (Hour) 11.30 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Stabbed with a Knife by give friend

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE Lt. N.E. Astorisis (Degree or title) Dep. Med. Exam. ADDRESS Pocomoke City Md DATE SIGNED 4/20/52

23. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial
DATE THEREOF May 2, 1952
NAME OF CEMETERY OR CREMATORY Roanoke Cemetery
LOCATION (City, town, or county) Roanoke, Ala. (State)
DATE REC'D BY LOCAL REG. April 28, 1952
REGISTRAR'S SIGNATURE Anne E. White
24. FUNERAL DIRECTOR Henry H. Watson ADDRESS Pocomoke, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1

RECEIVED
APR 30 1
BUREAU V. S.

94

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH
COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
MARYLAND
LENGTH OF STAY (in this place) 72 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Lee (Last) McGee

4. DATE OF DEATH (Month) April (Day) 6 (Year) 19 52

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH April 20 1879

9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Berlin Md R F D

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Hobbs

14. MOTHER'S MAIDEN NAME Sarah Mock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. No

17. INFORMANT AND ADDRESS Mrs. Margaret Hearn Berlin Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis

241 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c) Bronchial Asthma

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-, 19 48, to 4-6, 19 52, that I last saw the deceased alive on 4-6-, 19 52, and that death occurred at 11-15 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Clifford E. Lehet M.D. ADDRESS Berlin Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 4/9/52 | NAME OF CEMETERY OR CREMATORY Buckingham | LOCATION (City, town, or county) Berlin (State) Md

DATE REC'D BY LOCAL REG. 4/9/52 | REGISTRAR'S SIGNATURE Helen F Hayward | 24. FUNERAL DIRECTOR Owen A Bunting ADDRESS Berlin Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 14 1952
BUREAU V. S.

695

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH — COUNTY: Worcester — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bishop Rural
LENGTH OF STAY (in this place): 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bishop Rural
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Moses (Middle) (Last) Purnell
4. DATE OF DEATH (Month) Apr. (Day) 14 (Year) 1952
5. SEX: Male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 6, 1903
9. AGE last birthday: 48 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: chicken factory
11. BIRTHPLACE (State or foreign country): Newport Md. Wor. Co.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Purnell
14. MOTHER'S MAIDEN NAME: Katie Purnell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.: 218-24-5276
17. INFORMANT AND ADDRESS: Margorie Purnell, Bishop, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Stomach c̄ — Oct 1, 1951

15/X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Metastases

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 27 Oct 51
19b. MAJOR FINDINGS OF OPERATION: Ca of Stomach c̄ Metastases
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Oct, 1951, to 14 Ap, 1952, that I last saw the deceased alive on 14 Ap, 1952, and that death occurred at 2 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Hermann L. Rabbini M.D.
ADDRESS: 5 Bay St Berlin Md
DATE SIGNED: Apr 52

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Apr. 16, 1952
NAME OF CEMETERY OR CREMATORY: Sarah Dukes
LOCATION (City, town, or county) (State): Bishop, Md.

DATE REC'D BY LOCAL REG.: Apr. 15 - 52
REGISTRAR'S SIGNATURE: Roy Bergey
24. FUNERAL DIRECTOR: Henry H. Watson — ADDRESS: Pocomoke City, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A

1

T

RECEIVED
APR 17 1952
BUREAU V. S.

96

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
LENGTH OF STAY (in this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Jacob (Middle) (Last) Segal
4. DATE OF DEATH: (Month) April (Day) 17 (Year) 1952
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 23/1885
9. AGE last birthday: 66/9/24 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Cobbler
10b. KIND OF BUSINESS OR INDUSTRY: Own Shop
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Abraham Segal
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mr Albert M Segal 1916 Delancey Place Phila, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Carcinoma of Prostate — Interval Between Onset and Death: 3 yr

177X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b) metastases to rectum, recto vesical fistula — 1 yr

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Aug. 20/51
19b. MAJOR FINDINGS OF OPERATION: same as above
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1949, to April 17 1952, that I last saw the deceased alive on April 17, 1952, and that death occurred at 6.45 P.m., from the causes and on the date stated above.

SIGNATURE Jane Cohen (DEGREE OR TITLE) M D ADDRESS Snow Hill DATE SIGNED 4/17/52

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF April 19/51 NAME OF CEMETERY OR CREMATORY Har Neba LOCATION (City, town, or county) Philadelphia (State) Pa.

DATE REC'D BY LOCAL REG. 4/17/52 REGISTRAR'S SIGNATURE LeRoy Smith 24. FUNERAL DIRECTOR Alex C. Cummins ADDRESS Snow Hill, Md

Transportation permit issued 4/17/52 L.R.S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1

T

RECEIVED
APR 21 1952
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH: COUNTY Worcester STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke
LENGTH OF STAY (In this place) 46 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke
STREET ADDRESS (If rural, give location) Stockton Road

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) WILLIAM (Last) SHAY
4. DATE OF DEATH (Month) Apr (Day) 26, (Year) 1952

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec 22 1888
9. AGE last birthday: 63 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farm owner
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Teagle Shay
14. MOTHER'S MAIDEN NAME: Osha Mariner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Laura Shay, Pocomoke, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 10 Min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Heart Disease — Years

(c) Arteriosclerosis, generalized — Years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr, 1950, to Apr 26, 1952; that I last saw the deceased alive on Apr 26, 1952, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Charles N Nader MD Pocomoke City Md. Apr 28 1952.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Apr 28 1952
NAME OF CEMETERY OR CREMATORY: Downing Cemetery
LOCATION (City, town, or county) (State): Oak Hall, Virginia

DATE REC'D BY LOCAL REG.: April 28 1952
REGISTRAR'S SIGNATURE: Anne E. White
24. FUNERAL DIRECTOR ADDRESS: Henry H. Watson, Pocomoke, Md.

RECEIVED
APR
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04698

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: COUNTY Worcester MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin — LENGTH OF STAY (in this place) All life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Henry	(Last) Smith	4. DATE OF DEATH	(Month) 4 - (Day) 24 (Year) 1952
5. SEX Male	6. COLOR OR RACE A. A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH About 1872	9. AGE last birthday About 80 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own business	11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Smith			14. MOTHER'S MAIDEN NAME Rita Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs. Stella Smith, Berlin, Maryland		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic Deg. Myocarditis c̄ Anasarka	2 wks
442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) sec to Generalized Atherosclerosis	10 yrs
	(c) Nephrosclerosis	3 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prostate Hypertrophy c̄ Cystic Pyelitis — 1 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to 24 Apr, 1952, that I last saw the deceased alive on 24 Apr, 1952, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Fernando Rahlmann M.D.		5 Bay St Berlin, Md	4/25/52

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-27-'52	Evergreen Cemetery	Berlin, Worcester Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-26-52	Helen F. Hayward	James B. Dashiell	Easton, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1952
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04699

Reg. Dist. No. 350

1. PLACE OF DEATH — COUNTY: Worcester — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Pocomoke City
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Florida — COUNTY: 2
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (3)
STREET ADDRESS: (If rural, give location) 171

3. NAME OF DECEASED (Type or Print): (First) Lou Jeanie (Middle) White (Last)

4. DATE OF DEATH (Month) (Day) (Year): April 11, 1952 19

5. SEX: F

6. COLOR OR RACE: C.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: D.K.

9. AGE last birthday: 38 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Field work

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: D.K.

14. MOTHER'S MAIDEN NAME: Don't Know

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) No

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: David White — Husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Apoplexy — Several hours

334X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis with Hypertension — years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Hemiplegia in Sept 1952

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: N. E. Tartorius (Degree or title) Def. Med Exam — ADDRESS: Pocomoke City, Md — DATE SIGNED: 4/11/52

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 4/12/52 — NAME OF CEMETERY OR CREMATORY: Unionville Methodist — LOCATION (City, town, or county) (State): Pocomoke City, Md.

DATE REC'D BY LOCAL REG.: April 12, 1952 — REGISTRAR'S SIGNATURE: Anne E. White

24. FUNERAL DIRECTOR — ADDRESS: Henry H. Watson, Pocomoke, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
APR 16 1952
BUREAU V. S.